BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **NANCY MARIE NYARI** **AKA NANCY NYARI WEBER** **AKA NANCY MARIE WEBER** **AKA NANCY M. WEBER** **5001 Lakeview Circle** **Hoover, AL 35244** **Registered Nurse License No. 558799** Respondent.	Case No. 2011-694 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about February 7, 2011, Complainant Louise R. Bailey, M.Ed., RN, in her official capacity as the Executive Officer of the Board of Registered Nursing (Board), Department of Consumer Affairs, filed Accusation No. 2011-694 against Nancy Marie Nyari, aka Nancy Nyari Weber, aka Nancy Marie Weber, aka Nancy M. Weber (Respondent) before the Board of Registered Nursing. (Accusation attached as Exhibit A.)

2. On or about August 16, 1999, the Board issued Registered Nurse License No. 558799 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein, and will expire on October 31, 2012, unless renewed.

3. On or about February 7, 2011, Respondent was served by Certified and First Class Mail copies of the Accusation No. 2011-694, Statement to Respondent, Notice of Defense, Request for Discovery, and Discovery Statutes (Government Code sections 11507.5, 11507.6, and 11507.7) at Respondent's address of record which, pursuant to California Code of

Regulations, title 16, section 1409.1, is required to be reported and maintained with the Board, which was and is: 5001 Lakeview Circle, Hoover, AL 35244. A Certified Mail Domestic Return Receipt was returned to the Board signed by "Rose M. Nyari."

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

6. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2011-694.

7. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

8. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as taking official notice of all the investigatory reports, exhibits and statements contained therein on file at the Board's offices regarding the allegations contained in Accusation No. 2011-694, finds that the charges and allegations in Accusation No. 2011-694, are separately and severally, found to be true and correct by clear and convincing evidence.

9. Taking official notice of its own internal records, pursuant to Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement is $12,995.00 as of March 22, 2011.

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DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Nancy Marie Nyari, aka Nancy Nyari Weber, aka Nancy Marie Weber, aka Nancy M. Weber, has subjected her Registered Nurse License No. 558799 to discipline.

2. The Board has jurisdiction to adjudicate this case by default.

3. The Board is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Evidence Packet in this case:

a. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that Respondent was disciplined by the Alabama Board of Nursing resulting in the surrender of Respondent's Alabama nursing license;

b. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that Respondent was disciplined by the Ohio Board of Nursing for failing to properly follow a physician's order relating to narcotic medications and established procedures for wasting unused narcotics.

c. Respondent is subject to disciplinary action under Code section 2762, subdivision (a), on the grounds of unprofessional conduct in that between July 11, 2008 and February 9, 2009, Respondent obtained, possessed, and administered to herself Morphine and Demerol, Schedule II controlled substances, in violation of Health and Safety Code sections 11170 and 11173 while working at St. Francis Medical Center;

d. Respondent is subject to disciplinary action under Code section 2762, subdivision (a), on the grounds of unprofessional conduct in that between July 1, 2007 and February 18, 2010, Respondent obtained, possessed, and administered to herself a total of 1112.5 mg of Demerol, a Schedule II controlled substance, in violation of Health and Safety Code sections 11170 and 11173 while working at La Palma Intercommunity Hospital; and

e. Respondent is subject to disciplinary action under Code section 2762, subdivision (a), on the grounds of unprofessional conduct in that between February 3, 2010 to February 15, 2010,

Respondent obtained, possessed, and administered to herself controlled substances, in violation of Health and Safety Code sections 11170 and 11173 while working at Huntington Beach Hospital.

ORDER

IT IS SO ORDERED that Registered Nurse License No. 558799 issued to Respondent Nancy Marie Nyari, aka Nancy Nyari Weber, aka Nancy Marie Weber, aka Nancy M. Weber, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on July 8, 2011.

It is so ORDERED June 9, 2011.

Jeannie K. Lee

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

DOJ Matter ID:SD2010701910

Attachment:
Exhibit A: Accusation

Exhibit A

Accusation

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BEFORE THE
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STATE OF CALIFORNIA

In the Matter of the Accusation Against: **NANCY MARIE NYARI** **aka NANCY NYARI WEBER** **aka NANCY MARIE WEBER** **aka NANCY M. WEBER** **5001 Lakeview Circle** **Hoover, AL 35244** **Registered Nurse License No. 558799** Respondent.	Case No. 2011-694 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs (CA Board).

2. On or about August 16, 1999, the Board of Registered Nursing issued Registered Nurse License Number 558799 to Nancy Marie Nyari aka Nancy Nyari Weber aka Nancy Marie Weber aka Nancy M. Weber (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2012, unless renewed.

JURISDICTION

3. This Accusation is brought before the CA Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code (Code) provides that the CA Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides that the expiration of a license shall not deprive the CA Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811, subdivision (b) of the Code, the CA Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

6. Section 482 of the Code states:

"Each board under the provisions of this code shall develop criteria to evaluate the rehabilitation of a person when:

"(a) Considering the denial of a license by the board under Section 480; or

"(b) Considering suspension or revocation of a license under Section 490.

"Each board shall take into account all competent evidence of rehabilitation furnished by the applicant or licensee."

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

". . . .

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional

licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

". . . ."

8. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

"(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

". . . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

9. Health and Safety Code section 11170 states that no person shall prescribe, administer, or furnish a controlled substance for himself.

10. Health and Safety Code section 11173 states:

"(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

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"(b) No person shall make a false statement in any prescription, order, report, or record, required by this division.

". . . ."

REGULATIONS

11. California Code of Regulations, title 16, section 1444, states:

"A conviction or act shall be considered to be substantially related to the qualifications, functions or duties of a registered nurse if to a substantial degree it evidences the present or potential unfitness of a registered nurse to practice in a manner consistent with the public health, safety, or welfare. Such convictions or acts shall include but not be limited to the following:

"(a) Assaultive or abusive conduct including, but not limited to, those violations listed in subdivision (d) of Penal Code Section 11160.

"(b) Failure to comply with any mandatory reporting requirements.

"(c) Theft, dishonesty, fraud, or deceit.

"(d) Any conviction or act subject to an order of registration pursuant to Section 290 of the Penal Code."

12. California Code of Regulations, title 16, section 1445, states:

"(a) When considering the denial of a license under Section 480 of the code, the board, in evaluating the rehabilitation of the applicant and his/her present eligibility for a license will consider the following criteria:

"(1) The nature and severity of the act(s) or crime(s) under consideration as grounds for denial.

"(2) Evidence of any act(s) committed subsequent to the act(s) or crime(s) under consideration as grounds for denial which also could be considered as grounds for denial under Section 480 of the code.

"(3) The time that has elapsed since commission of the act(s) or crime(s) referred to in subdivision (1) or (2).

"(4) The extent to which the applicant has complied with any terms of parole, probation, restitution, or any other sanctions lawfully imposed against the applicant.

"(5) Evidence, if any, of rehabilitation submitted by the applicant.

"(b) When considering the suspension or revocation of a license on the grounds that a registered nurse has been convicted of a crime, the board, in evaluating the rehabilitation of such person and his/her eligibility for a license will consider the following criteria:

"(1) Nature and severity of the act(s) or offense(s).

"(2) Total criminal record.

"(3) The time that has elapsed since commission of the act(s) or offense(s).

"(4) Whether the licensee has complied with any terms of parole, probation, restitution or any other sanctions lawfully imposed against the licensee.

"(5) If applicable, evidence of expungement proceedings pursuant to Section 1203.4 of the Penal Code.

"(6) Evidence, if any, of rehabilitation submitted by the licensee."

COST RECOVERY

13. Section 125.3 of the Code provides that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS/DEFINITIONS

14. **AcuDose-RX** is a decentralized medication dispensing cabinet that automates the storing, dispensing, and tracking of medications in resident care areas. The system dispenses pharmaceutical medications to an individual authorized to access the system by user ID and password known only to that individual.

15. **Dilaudid** is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(K) and a dangerous drug per Business and Professions Code section 4022. Dilaudid is a trade name for hydromorphone.

16. **iBEX** is a computerized charting system used in hospitals. All entries in the medical record are made by users after logging into the system using password protected access.

17. **Meperedine**, also known by its brand name **Demerol**, is a Schedule II controlled substance as designated by Health and Safety Code Section 11055(b), and is a dangerous drug

pursuant to Business and Professions Code section 4022. Meperidine is a narcotic pain reliever similar to morphine and used to treat moderate-to-severe pain.

18. **Morphine** is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M) and a dangerous drug per Business and Professions Code section 4022.

19. **Pyxis** is a trade name for an automated single-unit-dose medication dispensing system that delivers medications, typically narcotics and controlled substances, to an individual authorized to access the system. The delivery of medications is accomplished when an authorized individual enters a password (or fingerprint) known only to that individual. The medication drawer, or container, is unlocked and the medication is removed from the machine and then administered to the designated patient. The medication transaction is recorded and stored into a data system. This data system captures the following information: who accessed the system, the name of the patient who is supposed to receive the medication, the time the system was accessed, the type of medication that was removed, and the quantity of medication that was removed. In addition, the name of the patient's physician prescribing the medication or; in the event there is no physician order, the annotation "override" will appear in lieu of the physician's name.

20. **Vistaril**, trade name for hydroxyzine hydrochloride, is a dangerous drug pursuant to Business and Professions Code section 4022, used for the symptomatic relief of anxiety and tension associated with psychoneurosis and as an adjunct in organic disease states in which anxiety is manifested.

FIRST CAUSE FOR DISCIPLINE

(May 25, 2006, Discipline by the Alabama Board of Nursing)

21. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that Respondent was disciplined by the Alabama Board of Nursing (Alabama Board). The circumstances are as follows:

a. On May 25, 2006, pursuant to the Alabama Board of Nursing Administrative Code, section 610-X-8-.15, Respondent signed and the Alabama Board of Nursing approved and accepted a voluntary surrender of Respondent's Alabama Nurse Temporary License no.

RP-009456. By Respondent's voluntary surrender, she acknowledged that the surrender had the same effect as revocation. Respondent voluntarily waived her right to a hearing in the matter, and should any request for reinstatement be submitted to the Alabama Board, the Alabama Board shall then have access to the entire investigation file.

SECOND CAUSE FOR DISCIPLINE

(May 14, 2007, Discipline by the Ohio Board of Nursing)

22. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that Respondent was disciplined by the Ohio Board of Nursing (Ohio Board). The circumstances are as follows:

a. On May 18, 2007, pursuant to Ohio Revised Code (ORC) section 4723.28(B), the Ohio Board placed probation terms, conditions, and limitations on Respondent's Ohio registered nurse license for a period of three (3) years as a result of a Consent Agreement that was agreed to by Nancy M. Weber, R.N. (Respondent) and the Ohio Board of Nursing.

b. Respondent admitted to the Ohio Board that her license was surrendered in Alabama, which had the same effect as a revocation. Respondent also admitted that in September 2006, during the course of her employment as an agency nurse working a 13 week float pool assignment at Grandview Hospital in Dayton, Ohio that she incorrectly followed a physician's order relating to narcotic medications and did not follow established procedures for wasting unused narcotics.

c. Respondent accepted numerous conditions on her registered nurse license with the Ohio Board. Respondent advised the Ohio Board that she did not plan to return to nursing practice in Ohio, but intended to obtain licensure in another state.

THIRD CAUSE FOR DISCIPLINE

(July 11, 2008 - February 9, 2009, Drug Diversion at St. Francis Medical Center)

23. Respondent is subject to disciplinary action under Code section 2762, subdivision (a), on the grounds of unprofessional conduct in that Respondent obtained, possessed, and administered to herself controlled substances in violation of Health and Safety Code sections 11170 and 11173. The circumstances are as follows:

a. An investigation was conducted by the Division of Investigation (DOI) for the CA Board following receipt of a complaint from St. Francis Medical Center (St. Francis) located in Lynwood, California. Respondent was assigned to the hospital emergency department through Cross Country TravCorps, a nursing registry. Respondent diverted controlled substances while employed at St. Francis during the period of July 11, 2008 through February 9, 2009. Respondent diverted Morphine and Demerol, Schedule II controlled substances, for patients who had no physician's order for the medication or the patient had been discharged from the hospital when Respondent withdrew the medication. On February 9, 2009, Respondent was interviewed by hospital staff and Respondent was found to be in possession of 1 ampoule of 75 mg of Demerol and 1 ampoule of 5 mg of Morphine. Respondent claimed that she had tried to return them back into the Pyxis, but she could not do it. After this interview, the St. Francis Pharmacy was contacted and ran an individual nurse report on Pyxis activity for Respondent since her start date in June 2008 until February 9, 2009, that revealed the following discrepancies:

Patient 14

b. The physician's orders for patient 14 dated December 9, 2008, at 0240 hours, provided for 75 mg Demerol IV every four hours. On December 9, 2008, Respondent withdrew 375 mg meperidine from the Pyxis, and only documented 75 mg wasted and none was administered. Furthermore, Respondent was not assigned to care for this patient. A total of 225 mg of meperidine was unaccounted for.

Patient 21

c. The physician's orders for patient 21 dated January 5, 2009, at 1915 hours, provided for Demerol 25 mg IM every 4 hours PRN, Vistaril 25 mg IM every 4 hours PRN, Do Not give Morphine, Low BP and at 1930 hours, provided for an order clarification, Demerol 25 mg IM every 4 hours PRN, Vistaril 25 mg IM every 4 hours PRN, Do Not give Morphine. On January 5, 2009, Respondent withdrew 75 mg meperidine from the Pyxis at each of the following times: 1918, 1930, 2244, and 2249 hours and documented 50 mg wasted for each withdrawal. There was no record of administration. On January 6, 2009, Respondent withdrew 75 mg meperidine from the Pyxis at each of the following times: 0115, 0348 and 0640

hours and only noted 25 mg wasted at 0640 hours. Again, Respondent did not make any entries in the Medication Administration Record (MAR) for this patient. According to the iBEX medication service, Respondent entered Demerol 50 mg IM, on February 5, 2009, at 1930 hours. Furthermore, Respondent was not assigned to care for this patient, obtained 300 mg of meperidine for this patient and only documented administering 50 mg to the patient leaving 250 mg of meperidine unaccounted for.

Patient 22

d. The physician's orders for patient 22 dated January 6, 2009, at 0130 hours provided for Demerol 25 mg IM every 3 hours PRN. However, an error was noted as this order was originally written as 0230 hours, but the 2 was changed to 1 by Respondent. The order at 0230 hours also provided for Demerol 25 mg IM New for breakthrough pain X 1 and Demerol 50 mg IM every 3 hours PRN pain. Respondent withdrew 50 mg meperidine from the Pyxis at 0203 hours and noted that 25 mg was wasted. Respondent withdrew 75 mg each time of meperidine from the Pyxis at 0210 and 0212 hours. Respondent withdrew 75 mg meperidine from the Pyxis at 0701 hours and noted that 25 mg was wasted. Respondent did not make any entries in the MAR for this patient. Furthermore, Respondent was not assigned to care for this patient, and Respondent wrote the physician orders for Demerol to coincide with her withdrawals in the Pyxis. Respondent obtained 225 mg of meperidine for this patient and only documented administering 150 mg to the patient, leaving 75 mg of meperidine unaccounted for.

Patient 24

e. The physician's orders for patient 24 dated February 5, 2009, at 2235 hours provided for Demerol 25 mg IVP (verbal order), at 2309 hours provided for Demerol 25 mg IVP (verbal order) and on February 6, 2009, at 0117 hours, provided for Demerol 75 mg IVP (verbal order). On February 5, 2009, Respondent made the following withdrawals from Pyxis in increments of 75 mg each of meperidine at 2050, 2217, 2250 and 2307 and only noted 50 mg wasted at 2307. On February 6, 2009, Respondent withdrew for this patient 75 mg meperidine at 0105 hours and noted 25 mg was wasted; withdrew 75 mg merperidine at 0111 hours and noted 50 mg was wasted; withdrew 75 mg meperidine at 0218 hours with no notation of wastage;

withdrew 75 mg meperidine at 0324 hours and noted 50 mg wasted; and withdrew 75 mg meperdine at 0616 hours and noted 25 mg wastage. According to the IBEX medication service, Respondent entered the following on February 5, 2009: Demerol 25 mg IVP at 2235 hours; Demerol 25 mg IVP at 2309 hours; and on February 6, 2009, Demerol 75 mg IVP at 0117 hours. However, the records indicate the patient was transferred to the Med-surg unit at 0100 hours. Respondent obtained a total of 475 mg of meperidine for this patient (after wastage) and only documented administering 125 mg to the patient leaving 250 mg of meperidine unaccounted for.

FOURTH CAUSE FOR DISCIPLINE

(May 2, 2009, Drug Diversion at La Palma Intercommunity Hospital)

24. Respondent is subject to disciplinary action under Code section 2762, subdivision (a), on the grounds of unprofessional conduct in that Respondent obtained, possessed, and administered to herself controlled substances in violation of Health and Safety Code sections 11170 and 11173. The circumstances are as follows:

a. An investigation was conducted by DOI for the CA Board following receipt of a complaint from First Class Nurses, a nursing registry which employed Respondent and stationed her at La Palma Intercommunity Hospital (La Palma). The investigation revealed that Respondent diverted controlled substances while she had been employed at La Palma during the period of July 1, 2007 through February 18, 2010. Respondent diverted a total of 1112.5 mg of Demerol, a Schedule II controlled substance. When interviewed, Respondent admitted to diverting the medication for self-use. Respondent made inaccurate entries in hospital and patient medical records and took patients' medications at La Palma as follows:/

Patient 2351

b. On May 2, 2009, Respondent withdrew a total of 750 mg of Demerol from the AcuDose machine for this patient, but only charted in the patient's Medical Administration Record (MAR) that she administered 75 mg at 0830 hours, 75 mg at 1230 hours and 25 mg at 1325 hours for a total of 175 mg. A total of 575 mg of Demerol was unaccounted for.

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Patient 9340

c. The physician's orders for patient 9340 dated May 2, 2009, provided for Demerol 50 mg IM every four hours PRN pain and Demerol 12.5 mg IV every hour for severe pain. On May 2, 2009, Respondent withdrew a total of 550 mg of Demerol from AcuDose for this patient, but only charted in the patient's MAR that she administered 12.5 mg at 1800 hours, and there was no record of wastage. A total of 537.5 mg of Demerol was unaccounted for.

FIFTH CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

25. Respondent is subject to disciplinary action under Code section 2762, subdivision (e), in that while on duty as a registered nurse at St. Francis Medical Center and La Palma Intercommunity Hospital, Respondent falsified, or made incorrect, inconsistent, entries in hospital, patient, or other records pertaining to the controlled substances, meperidine, Demerol and Morphine, as is detailed in paragraphs 23 and 24, above, which are incorporated herein by reference.

SIXTH CAUSE FOR DISCIPLINE

(February 15, 2010, Drug Diversion at Huntington Beach Hospital)

26. Respondent is subject to disciplinary action under Code section 2762, subdivision (a), on the grounds of unprofessional conduct in that Respondent obtained, possessed, and administered to herself controlled substances in violation of Health and Safety Code sections 11170 and 11173. The circumstances are as follows:

a. An investigation was conducted by DOI at the request of the CA Board as a result of a complaint the CA Board received from Huntington Beach Hospital, indicating that Respondent had diverted medications during the period of February 3, 2010 to February 15, 2010. Respondent had been employed at Huntington Beach Hospital from January 12, 2010 to February 20, 2010. Respondent diverted numerous doses of controlled substances for patients she was not assigned to care for while working as the Charge Nurse in the Med-Surg Unit at Huntington Beach Hospital. Respondent admitted to diverting the medication for self-use.

Respondent made inaccurate entries in hospital and patient records and took patients' medications as follows:

Patient 8822

b. The physician's orders for patient 8222 dated February 3, 2010, at 0620 hours, provided for Demerol 75 mg IM every 4 hours for pain and on February 4, 2010, Demerol 75 mg IM every 6 hours for pain. However, the doctor denied giving the two orders for Demerol and did not even know this patient was in the hospital. Furthermore, Respondent was not assigned to care for this patient.

c. On February 3, 2010, Respondent withdrew from the AcuDose-RX machine four doses of meperidine (generic for Demerol) for this patient 75 mg each at 2043, 2101, 2146 and 2207 hours (with a note that the patient refused the 75 mg dosage of meperidine at 2207 hours). Respondent charted in the patient's MAR that she gave the patient 75 mg of meperidine at 0700, 2050, and 2150 hours. There is no record of wastage of one 75 mg dose and 75 mg of meperidine is unaccounted for.

d. On February 4, 2010, Respondent withdrew from the AcuDose-RX a total of 750 mg of meperidine for this patient, charting in the patient's MAR that she attempted to give the patient 75 mg Demerol at 0050 hours and the patient refused. At 0700 and 2130 hours, Respondent charted in the MAR that she gave the patient 100 mg of Demerol at this time. There is no record of wastage and 350 mg of meperidine is unaccounted for.

e. On February 5, 2010, at 0116 hours, Respondent withdrew 100 mg of meperidine from AcuDose-RX. At 0149 hours it was noted in the AcuDose-RX report under the category entitled "wasted" "100 mg too soon." At 0227 hours, Respondent withdrew 100 mg of meperidine from AcuDose-RX, and at 0307 hours it was noted in the AcuDose-RX report under the category entitled "wasted" "100 mg Color." At 0323 hours Respondent withdrew 100 mg of meperidine from AcuDose-RX, and at 0334 hours it was noted in the AcuDose-RX report under the category entitled "wasted" "100 mg Contam." At 0335 hours, Respondent withdrew 100 mg of meperidine from AcuDose-RX. The AcuDose-RX report indicates that a total of 400 mg of meperidine was dispensed from AcuDose-RX and 300 mg was wasted leaving 100 mg of

meperidine unaccounted for. The patient's MAR indicated that Respondent administered 100 mg of Demerol at 0230 hours and 100 mg of Demerol at 0345 hours.

f. In summary, Respondent obtained a total of 650 mg Demerol for this patient per the AcuDose-RX report, however, she documented administering 625 mg of Demerol on the MAR, leaving 25 mg of Demerol unaccounted for. The doctor denied giving the two orders for Demerol and he did not know this patient was in the hospital. Furthermore, Respondent was not assigned to care for this patient.

Patient 7245

g. There was no physician's order for this patient dated February 14, 2010. On February 14, 2010, at 2338 hours, Respondent withdrew 150 mg of meperidine from the AcuDose-RX for this patient, and at 2339 hours, noted that a 100 mg partial dose was wasted. The Director of Nursing states that the doctor denied giving the order for Demerol for this patient, the patient notes indicate the patient was not complaining of being in pain, and that Respondent did not administer the 50 mg dose of Demerol for the patient on February 14, 2010, at 2338 hours.

h. The physician's order for this patient on February 15, 2010, at 0620 hours, was for Demerol 50 mg one time IM. At 0806 hours, Respondent withdrew 50 mg of meperidine from the AcuDose-RX. On February 15, 2010, at 0428 hours, Respondent noted that 50 mg of meperidine was wasted with a note that the order was changed. The MAR record dated February 15, 2010, at 0800 hours, indicated that Respondent administered 50 mg, but there is no documentation in the patient notes. The doctor denied giving the order for Demerol for this patient, and the patient notes indicate the patient was not complaining of pain.

Patient 1114

i. The physician's order for this patient on February 15, 2010, provided for Demerol 50 mg IM, one time. Respondent withdrew a total of 2 mg of Dilaudid for this patient per the AcuDose-RX report, and did not administer any Dilaudid to the patient. Dilaudid was not prescribed. Respondent withdrew 50 mg of Demerol for this patient and indicated on the MAR the patient refused the medication. There is also no indication Respondent wasted the 50 mg of

Demerol that she obtained for the patient. Respondent failed to document in the patient notes she administered the Demerol to the patient. A total of 2 mg Dilaudid and 50 mg of Demerol are unaccounted for.

Patient 0116

j. Respondent obtained a total of 125 mg of Demerol for this patient per the AcuDose-RX report. However, Respondent documented administering 100 mg of Demerol on the MAR leaving 25 mg of Demerol unaccounted for. Respondent also failed to document in the patient notes that she administered medication to the patient. There is no record of wastage.

Patient 7476

k. On February 9, 2010, at 2213 hours Respondent withdrew 2 mg of hydromorphone (Dilaudid) from the AcuDose-RX for this patient without a physician's order. At 2306 hours, Respondent withdrew 150 mg of meperidine (Demerol) from the AcuDose-RX for this patient. There was also no documentation indicating that Respondent administered the hydromorphone or meperidine to the patient. On February 10, 2010, at 2213 hours, Respondent withdrew 75 mg of meperidine for this patient but noted that the 75 mg dose was unavailable in the AcuDose-RX. At 0749 hours, Respondent withdrew 75 mg of meperidine from the AcuDose-RX and at 0756 hours, Respondent withdrew another 75 mg of meperidine and at 0757 hours it was noted in the AcuDose-RX report that a 75 mg vial of meperidine was broken. However, the doctor denied giving the February 10, 2010, order for Demerol (meperidine).

Patient 4846

l. Respondent withdrew a total of 100 mg of Demerol for this patient per the AcuDose-RX report, but only documented administering 75 mg of Demerol on the patient's MAR leaving 25 mg of Demerol unaccounted for. The AcuDose-RX report indicates Respondent dropped two doses of Demerol, which the Director of Nursing reported is highly suspicious.

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SEVENTH CAUSE FOR DISCIPLINE

(False Entries in Hospital/Patient Records)

27. Respondent is subject to disciplinary action under Code section 2762, subdivision (e), in that Respondent, while on duty as a registered nurse at Huntington Beach Hospital, falsified, or made incorrect, inconsistent, entries in hospital, patient, or other records pertaining to the controlled substances meperidine, Demerol, and Dilaudid, as is detailed in paragraph 26, which is incorporated herein by reference.

EIGTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct – Use of Controlled Substances in a Manner Dangerous or Injurious to Self)

28. Respondent is subject to disciplinary action under Code section 2762, subdivision (b), on the grounds of unprofessional conduct in that Respondent self-administered controlled substances without a prescription, to an extent or in a manner dangerous to herself, as is more fully set forth in paragraphs 23 and 24, above, which are incorporated herein by reference.

29. The circumstances are that Respondent admitted during a DOI interview on March 16, 2010, that when she worked at Huntington Beach Hospital, she made some mistakes in documenting medication, and that she is a drug addict. She admitted that she took medications, Demerol or Dilaudid, and would shoot up in her hip at home. Respondent admitted that she shot up Demerol about three or four weeks earlier and that she "Doctor shopped" so she could get more Methadone tablets. When asked about working at St. Francis Hospital, Respondent admitted that she had Morphine and Demerol in her possession when the staff questioned her. Respondent said she tried to put the medication back and did not have a chance before they called her in to question her. When asked by the DOI investigator, Respondent agreed to submit to a drug screen, and a urine specimen was immediately obtained from Respondent and given to the investigator. On March 18, 2010, the investigator obtained Respondent's drug test results from Quest Diagnostics, which came back positive for Methadone.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 558799, issued to Nancy Marie Nyari, aka Nancy Nyari Weber, aka Nancy Marie Weber, aka Nancy M. Weber;

2. Ordering Nancy Marie Nyari, aka Nancy Nyari Weber, aka Nancy Marie Weber, aka Nancy M. Weber to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 2/7/11

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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